

National Guidelines for Child and Youth Behavioral Health Crisis Care

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Acknowledgments

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Forward

From the desk of Dr. Miriam Delphin-Rittmon, Assistant Secretary for Mental Health and Substance Use, U.S. Department of Health and Human Services

Children, youth, and young adults across the nation are experiencing a rising wave of emotional and behavioral health needs. All too often, these young people are subjected to unnecessary hospitalizations, long stays in inpatient facilities, justice system involvement, disproportionate school discipline, and out-of-home placements. There are also pronounced disparities impacting young people of color, families from low-income communities, and sexual minority youth. For too many youth, these crises end tragically.

All youth and families should have access to a robust crisis response system that has developmentally appropriate policies, staffing, and resources in place to respond to their needs equitably and effectively—the right supports, at the right time, delivered the right way.

As of July 2022, people in every state, tribal nation, and U.S. territory can access the Suicide and Crisis Lifeline network by calling or texting a simple three-digit number, 988. SAMHSA aims to provide as much support as possible to facilitate the development of a spectrum of services that are effective in addressing the needs of individuals in crisis, including our nation's youth.

SAMHSA's *National Guidelines for Child and Youth Behavioral Health Crisis Care* describes a framework that states and localities across America can consider as they develop or expand their crisis safety net for youth and families. Ultimately, SAMHSA envisions 988 as part of a robust crisis response system that is as widely recognized and understood as 911.

This document captures recommendations from an expert children's crisis continuum workgroup, best practices identified in the research, and learnings from pioneering children's crisis response programs. It is not the final word—it is a beginning. With the implementation of 988, we will continue to learn better ways of engaging, serving, and supporting young people in crisis and their families. Together, we can build a crisis response system that both responds effectively to all youth in crisis *and* prevents emotional and behavioral health needs from escalating to crisis.

Miriam E. Delphin-Rittmon, PhD
Assistant Secretary for Mental Health and Substance Use
U.S. Department of Health and Human Services

Executive Summary

The National Suicide Prevention Lifeline transitioned to the 988 Suicide and Crisis Lifeline in July 2022. This free, confidential system provides 24/7/365 behavioral health crisis response through text, chat, and voice calls. Congress increased its appropriation for the crisis center service to address rising rates of behavioral health crises across America. This transition represents an unparalleled opportunity to improve the delivery of crisis care in every community in the country. It also elevates our responsibility to ensure that crisis response services meet the needs of children, youth, and young adults, and their families and caregivers.

The need for developmentally appropriate crisis response services for youth is acute. Yet, while many crisis response systems have robust services in place for adults, there are often considerable gaps in capacity to serve youth and families. Too often, youth experiencing behavioral health crisis face hospitalization or justice system involvement, instead of the home- and community-based services they need to de-escalate and stabilize. This is especially true for youth populations that have experienced high unmet behavioral health needs, including LGBTQ+, Black, and American Indian and Alaska Native youth.

The National Guidelines for Child and Youth Behavioral Health Crisis Care provides guidance on how states and communities can address these gaps. It offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of American children and their families experiencing a behavioral health crisis.

Core Principles for Delivering Crisis Response to Children, Youth, and Families

The first priority is keeping youth in their own homes and keeping families intact whenever possible. Youth and families should receive the most effective, least restrictive services that will meet their needs. To the extent it can be safely done, children and youth should receive services in home- and community-based settings. When needed, crisis stabilization facilities should have child-, youth-, and family-specific policies, staff, and physical spaces to meet a full range of developmental needs. Across all contexts, crisis responders should collaborate with, engage, and empower youth and families as early as possible to prevent avoidable hospitalizations and justice system involvement.

SAMHSA strongly encourages youth crisis systems to:

- Keep youth in their home and avoid out-of-home placements, as much as possible.
- Provide developmentally appropriate services and supports that treat youth *as* youth, rather than expecting them to have the same needs as adults.
- Integrate family and youth peer support providers and people with lived experience in planning, implementing, and evaluating services.
- Meet the needs of *all* families by providing culturally and linguistically appropriate, equity-driven services.

Youth crisis systems should also adopt the core principles outlined in the National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit:

1. Addressing Recovery Needs

2. Trauma-Informed Care
3. Significant Role for Peers
4. Zero Suicide/Suicide Safer Care
5. Safety/Security for Staff and People in Crisis
6. Crisis Response Partnerships with Law Enforcement, Dispatch, and Emergency Medical Services

Core Components of Child, Youth, and Family Crisis Response

SAMHSA recommends a broad conceptualization of crisis services as including three core components designed to meet the needs of a person in behavioral health crisis and include: 1. Someone to talk to; 2. Someone to respond onsite, if the situation cannot be resolved through the crisis call center; and 3. Somewhere to go if the situation is better addressed with facility-based staffing, security, and resources.

While this framework was developed for adults in crisis, SAMHSA envisions a similar three-component design for child- and family-serving crisis services:

Someone to Talk To: Crisis Call Centers. Operating 24/7/365, crisis call centers should offer developmentally appropriate assessment, sensitive de-escalation supports, and connections to ongoing care, when needed. Staff should include clinicians, family and youth peer support providers, and other team members with specialized training to respond to youth and families.

Someone to Respond: Mobile Response Teams. Mobile crisis teams go where they are needed to respond to crises—whether in children’s homes, their schools, or their communities. They should provide immediate supports, safety planning, and follow-up with qualified crisis responders, including family and youth peer support providers. They should prioritize keeping youth in their homes if it is safe to do so.

A Safe Place to Be: Crisis Receiving and Stabilization Services. Stabilization supports for youth and families can include in-home services delivered over several weeks. When appropriate for the needs of the youth, supports can also include developmentally appropriate, trauma-informed care provided in crisis care facilities, emergency departments, and hospital settings.

Integrating Systems of Care Approach in Serving Children, Youth, and Families in Crisis

The youth crisis continuum should be rooted in the System of Care framework. Services should be family-driven, youth-guided, and culturally and linguistically responsive (Stroul et al., 2021). Agencies should coordinate and collaborate across systems to provide individualized care for youth and families, emphasizing services in the home or community. To achieve this, crisis response systems should partner with agencies across the continuum of care, including schools, family and peer support, community organizations, child welfare and foster care, juvenile justice, and pediatricians and other primary care providers.

Special Populations and Settings

All youth and families should have access to crisis care that meets their needs, and these needs vary across communities and groups. Crisis care providers should be trained to recognize and respond to the needs of a great diversity of youth. This group includes infants and young children; transition-age youth; racial and ethnic minority youth, including youth in Tribal communities; lesbian, gay, bisexual, transgender, queer,

intersex, and other sexual and gender minority (LGBTQI+) youth; youth who are immigrants or refugees; youth experiencing homelessness; and youth with intellectual or developmental disabilities, among other important service populations. All crisis response systems should engage diverse clinicians and peers who reflect the diverse communities they serve. Crisis care providers in communities with large non-English speaking populations will need to recruit multi-lingual and multi-cultural staff and have the appropriate policies and sensitivities that are relevant to the needs of youth who may be undocumented. Crisis care providers in rural areas will need to strategically engage natural supports in the community to create a crisis response workforce that can cover large geographic areas. Telehealth services may be used as a service and support alternative as appropriate.

Introduction

The transition to the 988 Suicide and Crisis Lifeline in July 2022 is an unprecedented opportunity to expand behavioral health crisis systems nationwide. In 2020, Congress enacted laws to establish 988, a universal three-digit number to help people who are in suicidal, mental health, or substance use crisis (Public Law, 2018). People who call or text 988 or chat via 988lifeline.org are connected to the Suicide and Crisis Lifeline (formerly known as the National Suicide Prevention Lifeline), which currently consists of more than 200 crisis centers that operate 24 hours a day, seven days a week (Our Crisis Centers, n.d.).

The transition to 988 has already resulted in an increase in the number of calls that are routed through the Lifeline network. However, many states and communities do not have staffing or services in place to provide timely, appropriate crisis response for youth. This need is especially acute in rural and frontier regions. Even in more populated areas, youth in crisis may experience days or weeks of hospital boarding or be transported hundreds of miles away to an in-patient facility (Mental Health Oversight and Accountability Commission, 2016).

The *National Guidelines for Child and Youth Behavioral Health Crisis Care* provides a roadmap that can be used to truly make a positive impact in the lives of children, youth, young adults, and families in communities across America.

About this Document

The main purpose of the *National Guidelines for Child and Youth Behavioral Health Crisis Care* is to offer best practices, implementation strategies, and practical guidance. Although there is some discussion of research findings and statistics, this is not a research document. This document does include both research-based guidance and learnings shared by SAMHSA's Children's Crisis Continuum expert panel (2021).

This document is intended to be a starting point for building a 988 crisis system that supports youth and families effectively. It builds on previous SAMHSA guidance, including the following key publications, as well as recommendations from the expert panel. It **complements, not replaces**, SAMHSA's previous work.

- [National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit](#), released in 2021 by SAMHSA
- [Crisis Services: Meeting Needs, Saving Lives](#), released in 2021. Included SAMHSA's *Best Practice Toolkit* and articles by the National Association of State Mental Health Project Directors (NASMHPD)
- [Ready to Respond: Mental Health Beyond Crisis and COVID-19](#), released in 2021. Collection of 10 crisis response briefs developed by NASMHPD in response to the pandemic

Language and Terminology

The language we use to talk about behavioral health shapes how we think about behavioral health. Some terms that are acceptable today may be considered stigmatizing in the future. Throughout this document, we have tried to use recovery-oriented language that promotes acceptance and person-centered support.

Terms for discussing people and populations also change over time. Wherever specific racial, ethnic, cultural, or other identity-based groups are discussed in this document, we have tried to use language that is inclusive and preferred by those communities.

“Youth” and “young people” are used throughout this document to describe children, youth, and young adults of transition age who are still involved in youth-serving systems.

“Families” is meant inclusively. It refers to all individuals with caregiving responsibility for a young person, including parents, stepparents, guardians, foster families, grandfamilies or kinship families, or other caregivers (Generations United, n.d.). In some contexts, it refers to others in the home who may be impacted by a young person’s crisis (such as siblings).

Youth Crisis in Context

In the past year, President Biden, U.S. Surgeon General Vivek Murthy, and a collective comprised of the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association have all called attention to urgent youth mental health needs (Biden, 2022; Office of the Surgeon General, 2021; American Academy of Pediatrics, 2019).

Up to one in five children has a reported mental, emotional, developmental, or behavioral disorder (Perou et al., 2013), and youth mental health has worsened over the past decade (Centers for Disease Control and Prevention, 2020). During the pandemic, rates increased for positive suicide risk screens, anxiety symptoms, and depression symptoms among youth (Lantos et al., 2022; Mayne, 2021; Office of the Surgeon General, 2021). Youth with mental health challenges also experience higher risk for early substance use, regular substance use, and substance use disorders (Welsh et al., 2020).

Although the national rise is alarming on its own, some historically underserved youth populations are disproportionately burdened by behavioral health crisis. For example, non-Hispanic American Indian or Alaskan Native (AI/AN) children have the highest rate of suicide. LGBTQ high school students attempt suicide at a rate approximately four times greater than non-LGBTQ youth (Johns et al., 2020). Suicide attempts among Black youth are rising faster than among any other racial or ethnic group, and Black children under age 13 are twice as likely to die by suicide as their White peers (Emergency Taskforce on Black Youth Suicide and Mental Health, 2019; Lindsey et al., 2019).

Traditional Youth Crisis Response System

In the past—and in most areas of the U.S. today—youth in crisis have often become involved in systems that may cause harm instead of providing appropriate support. **There is an urgent need to expand and promote a comprehensive, trauma-informed, customized crisis continuum for youth and families.**

Emergency Departments and Hospitalization

When youth are experiencing a behavioral health crisis, or when an adult believes them to be in crisis, the young person is often taken to an emergency department (ED). Nationwide, pediatric behavioral health ED visits have increased dramatically in recent years, particularly for youth with Medicaid or no health insurance (Bostic & Hoover, 2020; Lo et al., 2020).

After initial assessment, youth will typically stay in the ED or be transferred to an in-patient medical unit until a “bed” becomes available at an in-patient psychiatric facility. This process is referred to as “boarding,” and it may last for hours, days, or (in extreme cases) weeks (Hazen & Prager, 2017; McEnany et al., 2020). Pediatric psychiatric ED boarding has been described as a national crisis, and it has worsened during the pandemic (Cutler et al., 2022).

There are many reasons why it is not ideal for youth to visit the ED or be boarded when they are in crisis. Examples include (Bostic & Hoover, 2020):

- Youth in the ED may experience seclusion; physical restraint; and environments that are crowded, loud, and potentially frightening.

- ED staff may not be trained to respond to youth crisis, and youth generally do not receive mental health treatment when boarded.
- Many youth are brought to the ED repeatedly for costly crisis visits, rather than transitioning to ongoing care and community-based alternatives.

There are also important racial and ethnic disparities related to ED boarding. Youth visits to the ED for psychiatric reasons are rising most quickly for Black and Hispanic or Latino youth (Kalb et al., 2019). In a study of more than half a million youth who were physically restrained in the ED, Black youth were almost twice as likely as White youth to be restrained (Nash et al., 2021).

Justice System

Youth in crisis also frequently interact with law enforcement officers, either because the officers are first responders for 911 calls or because they are where youth are (e.g., school resource officers). Although youth-focused Crisis Intervention Training (CIT) and similar programs for police are increasingly widespread, many law enforcement officers are not adequately trained or resourced to respond effectively to youth in behavioral health crisis (Bunts, 2021; Kubiak et al., 2018).

Police involvement in crisis situations can provoke fear, anxiety, and trauma response or re-traumatization, particularly among Black, Indigenous, and other People of Color (BIPOC) youth and families and those in low-income, segregated communities (Baker & Pillinger, 2019; Feldman et al., 2019). For example, Black and Hispanic or Latino communities are significantly more likely than Whites to experience police violence, police-involved deaths, and incarceration. Asian American or Pacific Islander and Hispanic or Latino youth are more likely than other young people to have undocumented legal status or to have family members with undocumented status. These youth and families may experience fear of or past trauma from arrest, incarceration, or deportation. (Snowden et al., 2008; Delva et al., 2013). Having these experiences, having loved ones with these experiences, or worrying about these experiences can create significant psychological distress (Graham et al., 2020).

LGBTQ individuals have also experienced discrimination, harassment, and profiling by law enforcement, which weakens community trust (Mallory et al., 2015). LGBTQ youth are overrepresented in the justice system, especially LGBTQ girls and LGBTQ youth of color (Wilson et al., 2017; Jones, 2021). They are more likely than non-LGBTQ youth to experience family rejection and homelessness, so they are disproportionately likely to be jailed for running away and they lack resources when they are released (Center for American Progress, 2016).

Police presence in schools has nearly doubled over the last two decades, and students experiencing mental health challenges (especially students of color) are disproportionately subjected to school discipline, arrest, and incarceration (Choi et al., 2021; Irvine, 2010). LGBTQ youth are overrepresented in the justice system, especially LGBTQ girls and LGBTQ youth of color (Wilson et al., 2017; Jones, 2021). In schools, the management of disruptive behavior in classrooms too often results in arrest of Black youth, compared to other strategies that are applied for non-Black youth. This contributes to early juvenile and eventual criminal justice system involvement due to an accumulation of justice system interactions, which exacerbates school-to-prison pipeline (Nance, 2016). Black youth are at higher risk of being detained or committed in juvenile facilities (Rovner, 2021). They are also at higher risk of being tried and sentenced as adults (Thomas, 2018). LGBTQ youth also experience a school-to-prison pipeline, receiving disproportionate punishments for activities such as violating gender norms (e.g., dress codes), engaging in

public displays of affection, or defending themselves against bullying and harassment (Snapp et al., 2014; Snapp & Russell, 2016).

Core Youth Crisis Services

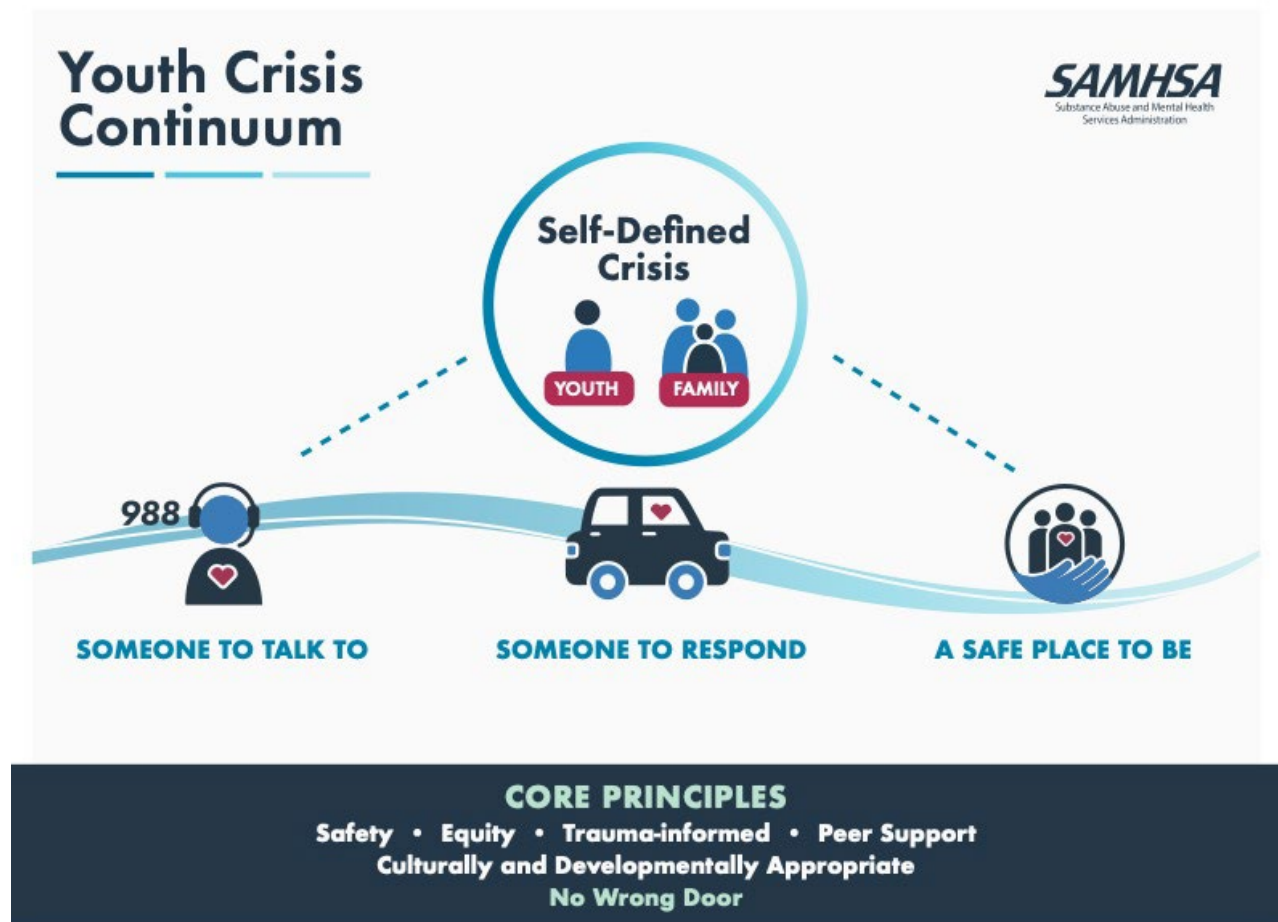
SAMHSA's *National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit* described three core services as essential to a comprehensive crisis response system. This crisis response system should include having “someone to talk to” when a person is experiencing crisis; and if that does not resolve the crisis, having “someone to respond” in their home or community; and if that does not resolve the crisis, having “a safe place to be” for de-escalation and stabilization.

These three components comprise a **stepped care system** in which families receive the most effective, yet least restrictive and least resource-intensive, services they need. In other words, many calls, chats, and texts can be resolved simply by talking with the 988 call responders. Of those that remain, many can be resolved with the mobile crisis team.

1. ***Someone to Talk To – Regional Crisis Call Center:*** A toll-free, single-point-of-access line, operating 24/7 and staffed by individuals with child and adolescent behavioral health expertise. This includes the 988 Suicide and Crisis Lifeline network as well as other local and statewide crisis call centers.
2. ***Someone to Respond – Crisis Mobile Team Response:*** Mobile crisis teams that respond 24/7 to homes, schools, primary care settings, or any other location of the young person in crisis. Mobile crisis teams are made up of behavioral health practitioners, e.g., social workers, psychologists and psychiatrists, paraprofessional crisis stabilizers, and peer support providers.
3. ***A Safe Place to Be – Crisis Receiving and Stabilization Services:*** Facilities operating 24/7 to provide short-term de-escalation and care for youth who have crisis needs beyond what the mobile team can provide. Stabilization services may also include ongoing, in-home interventions that are delivered over a period of several weeks.

Crisis receiving services may also include emergency departments and inpatient hospitalization. However, in many situations, hospitals are not an ideal situation for youth in crisis, because of the reasons discussed above in [Emergency Departments and Hospitalization](#). SAMHSA strongly advises that, unless safety is an immediate or imminent concern, crisis response systems be designed to provide safe and effective alternatives to hospitalization, and that emergency departments and hospitals only be used as a last resort.

Services will vary in each community. For example, some regions have a single mobile response team service that operates throughout the county or state, while more populated areas may have multiple teams in the same geographic area.



This section discusses each of the three core services in more detail. Across all services, SAMHSA strongly encourages:

- Keep youth in their home and avoid out-of-home placements as much as possible.
- Provide developmentally appropriate services and supports that treat youth *as* youth, rather than expecting them to have the same needs as adults.
- Integrate family and youth peer support providers and people with lived experience in planning, implementing, and evaluating services.
- Meet the needs of *all* families by providing culturally and linguistically appropriate, equity-driven services.

Someone to Talk To – Crisis Call Hub Services

In July 2022, the National Suicide Prevention Lifeline transitioned to the 988 Suicide and Crisis Lifeline, which includes call, text, and chat points of access through the more than 200 crisis call centers operated by the Lifeline nationwide. Creating a single point of access makes it easier for people to obtain behavioral health-focused crisis services (Manley et al., 2018).

Crisis call centers provide developmentally appropriate, brief screening and intervention via telephone call, text, and chat. Contact centers should be staffed by clinical and paraprofessional behavioral health staff that have specialized training to meet the needs of youth, including licensed behavioral health professionals and family and youth peers.

Expectations and Best Practices

The following are suggested strategies for ensuring that crisis center services are responsive to youth and families. This guidance includes best practices identified in the literature, learnings from communities that have implemented crisis response systems, and guidance from SAMHSA’s Children’s Crisis Continuum expert panel.

Essential Operations

- Operate every moment of every day (24/7/365). Be staffed to answer every contact from youth and families, as well as from agencies and organizations that serve these populations (e.g., schools). If resources are not available to support this, coordinate overflow coverage with another youth- and family-trained crisis center (SAMHSA, 2020a).
- Have protocols and resources in place to quickly access translation services, and TTY (teletypewriter) for those who are deaf or hard of hearing. Have sufficient capacity and oral fluency in languages that match the community need.
- Gather data on call volume, response time, user satisfaction, and outcomes to inform a continuous quality improvement process, which should include regular review of call data to identify and address disparities, identify service gaps, and determine training needs (Vincent & Viljoen, 2020).

Technology

- Incorporate Caller ID functioning (SAMHSA, 2020a).
- Implement GPS-enabled technology in collaboration with partner crisis mobile teams to dispatch care more efficiently (SAMHSA, 2020a).
- Build technological capacity to incorporate texting, chat, and video. Recent research has shown that telehealth might improve help-seeking behavior for youth, and some youth report texting is their preferred method of communication (Evans et al., 2013; Kauer et al., 2014).
- Utilize real-time regional bed registry technologies that integrate information about which facilities have openings for youth (SAMHSA, 2020a). (Recognize, however, that most users will not need inpatient services.)

Note about Bed Registries

Bed registries are online databases that show current availability at behavioral health inpatient settings. “Bed” is defined by the state or locality and can include “public and private psychiatric hospitals, psychiatric units in general hospitals, crisis stabilization units (short and long term), crisis respite centers, residential settings, social detox centers, and recovery homes.” Bed registries reduce ED boarding and streamline referrals (Morrissette, 2021). [Improving Access to Behavioral Health Crisis Services with](#)

[Electronic Bed Registries](#) from NASMHPD provides useful examples of states that include information about youth-specific settings and services.

[Staffing and Training](#)

- Staff crisis call centers with an interdisciplinary team of child and adolescent behavioral health clinicians, family and youth peers, and other trained team members (SAMHSA, 2020a). As much as possible, hire staff whose racial, ethnic, linguistic, and sexual orientation or gender identities are representative of the communities served.
- Ensure all responders receive relevant training on developmentally appropriate supports and services available in the region or community. Other important training topics may include:
 - De-escalation strategies that are specific to youth and families, including how to navigate family systems and engage families as co-supporters (Bunts, 2021; Bostic & Hoover, 2020).
 - Mandatory reporting requirements in cases of child abuse and neglect, including how to respond to youth and families describing abuse or neglect, how to assess for the child's immediate safety, and when and how to make a report (Cash et al., 2020).
 - Typical developmental milestones, challenging behaviors, and youth-specific signs and symptoms of behavioral health challenges. Training should focus on how these issues may present during a crisis call specifically (see [Table 1](#) in "Improving the Child and Adolescent Crisis System: Shifting from a 9-1-1 to a 9-8-8 Paradigm," Bostic & Hoover, 2020).
 - Conducting safety planning and strengths-based caller engagement with youth and families (Bostic & Hoover, 2020).
 - Promoting positive behavioral health, positive childhood experiences, and resiliency (Health Outcomes from Positive Experiences, n.d.).
 - Bias, racism, cultural responsiveness, and LGBTQI+ affirming care, especially on how these issues manifest in crisis management and response (e.g., use of preferred pronouns; addressing culturally relevant fears around the potential involvement of police, child protective services, or immigration services) (Bunts, 2021).
 - Stressors and concerns that are important to youth, such as issues related to school, peer rejection, romantic breakups, and bullying (Bostic & Hoover, 2020).
 - Adverse Childhood Experiences (ACEs); trauma and trauma-informed care; and the social drivers of health, also known as social determinants of health (Administration for Children and Families, n.d.; Bruner, 2017, Settapani, 2018).

[Providing Services](#)

- Assess for risk of self-harm or suicide in a manner that meets Lifeline Suicide Risk Assessment Standards and assess for risk of harm to others. Use developmentally appropriate tools and protocols (SAMHSA, 2020a).
- The *National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit* also directs Lifeline crisis center staff to adhere to the Lifeline's [Imminent Risk of Suicide](#) model (SAMHSA, 2020a).

- If needed, coordinate connections to mobile crisis response teams and crisis facilities that offer developmentally appropriate services. Provide warm hand-offs and coordinate transportation as needed (SAMHSA, 2020a).
- With the family's permission, schedule home- and community-based follow-up appointments in a manner synonymous with a warm handoff to support connection to ongoing care following a crisis episode, in collaboration with the mobile response team (SAMHSA, 2020a).

Youth Crisis Response Case Example: Sally, Age 7

Fictitious names and the vignette are adapted from Bostic, J., Hoover, S. (2020). Improving the Child and Adolescent Crisis System: Shifting from a 9-1-1 to a 9-8-8 Paradigm.

Sally has not gone to or stayed at school since the beginning of the school year, typically screaming and crying when approaching the school. Today, she screamed and bit at a teacher, and the school told Sally's parents they will have to report her as habitually truant if she is unable to attend school regularly. Sally's parent, John, texts 988.

The 988 responder begins by asking questions to assess Sally's imminent risk of harm to herself or others and to clarify Sally's safety in other ways (e.g., whether there are specific people at school whom Sally is frightened of). The 988 responder explores what John's reasons or goals are for calling now. John's fear is that the police or child protective services will be called if Sally is reported as truant, and that she and her siblings may all be taken from the home. The 988 responder offers de-escalation strategies (e.g., playing music to distract Sally while driving to school) and consultation with the mobile crisis team. The mobile crisis team has an initial phone call to allay John's fears of being reported to the police or child protective services. The mobile crisis team arrives at Sally's home and works with John to further de-escalate the crisis, find solutions, and create an action plan (e.g., having Sally enroll in virtual schooling temporarily, accessing community-based care if Sally continues to experience anxiety about leaving home).

Someone to Respond – Mobile Crisis Team Services

Mobile crisis teams or mobile response teams support families wherever the crisis is taking place in the community. Youth and families may request mobile crisis services themselves, although youth-serving systems (e.g., schools) frequently make these requests as well. Mobile response teams support de-escalation, assessment, education and coping skills, safety planning, identification of next steps, referrals to additional care (as needed), transitions to crisis stabilization or hospital settings (as needed), and follow-up.

988 is one route to access support from mobile crisis teams. Mobile response teams may also be dispatched after a call directly to the mobile service; a call to another local crisis contact line; or through coordination with 911, law enforcement, or hospital systems.

There are many mobile crisis response teams that do not currently have partnerships in place with Lifeline centers. As noted elsewhere, all 988 calls are routed to Lifeline centers. Establishing connections between mobile response teams and Lifeline centers is an important component of building a system to support 988 (McKeon, 2021).

Mobile response teams include professional and paraprofessional staff such as mental health counselors, crisis intervention specialists, social workers, nurses, trained youth or family peer support providers, and psychologists. Response from mobile response units is typically in teams of two; however, this may differ if the team is dispatched from a staffed facility or if, as in rural or frontier communities, telehealth services are utilized.

Important Note

Youth crisis services are centered on de-escalation and stabilization **within the home and community**. This is an important priority for all crisis services and is especially important for youth. If it is safe for the young person and their family, **every effort should be made to help them stay in their current living environment**, with family or other natural supporters actively participating in the young person's care and stabilization.

Expectations and Best Practices

Many states and localities have implemented successful mobile response teams for youth. This section integrates community-defined evidence as well as best practices from the literature.

Essential Operations

- Respond to crises on location in home- and community-based settings, including schools and post-secondary institutions, recreational centers, homeless shelters, and other community centers (SAMHSA, 2020a).
- Implement real-time GPS technology in partnership with the region's crisis center hub (SAMHSA, 2020a).
- Be available to respond quickly to crises. Arriving onsite within one hour of dispatch is the general standard most mobile crisis teams follow. For mobile response systems covering a large geographic area, there may need to be multiple provider teams at different locations. Considerations for rural and frontier communities are discussed in the [Rural and Frontier Communities](#) section.

Staffing and Training

- Have access to a licensed and/or credentialed clinician in a supervisory role who has expertise and experience using evidence-based assessment tools with youth populations. The clinician may be onsite, or they may consult over the phone or through video (Bostic & Hoover, 2020; SAMHSA, 2020a).
- Incorporate youth and family peers within the response team (SAMHSA, 2020a).
- Respond without law enforcement accompaniment unless special circumstances warrant their inclusion. Safe reduction of unnecessary police involvement is critical for youth of color, who are more likely than their White peers to face harsh consequences like school exclusion and arrest (Bunts, 2021; Maryland State Department of Education, n.d.; McFadden, 2021; U.S. Commission

on Civil Rights, 2019). Additionally, avoiding unnecessary police engagement during a mental health crisis allows for more efficient use of scarce law enforcement resources.

- Provide staff training about how to describe mobile response services to youth, their caregivers, and other callers. The entire approach should be framed in terms of acceptance and help, never blaming youth or families. Situations which result in frequent calls for the same young person should be framed as special challenges that need to be addressed with action plans that support transition to community-based or wraparound services.

The following are examples of required training topics that some states ([New Jersey](#), [Nevada](#)) have implemented for certifying their mobile response staff.

- Developmental tasks of childhood and adolescence
- Family relationships
- Child and youth engagement and motivation, including motivational interviewing
- Culturally responsive care
- Crisis intervention with LGBTQ youth
- Positive behavior support
- Crisis response protocol
- Assessing violence risk; using suicide assessment tools
- Crisis intervention for youth with developmental disabilities
- Child traumatic stress, trauma-informed care, Trauma Focused Cognitive Behavioral Therapy
- DSM 5 diagnostic categories (children and youth)
- Youth substance use
- Adolescent Screening, Brief Intervention, and Referral to Treatment (A-SBIRT)
- Safety awareness considerations for working in the community
- Domestic violence and intimate partner violence
- Child abuse and reporting laws

[Onsite Needs: Assessment Tools](#)

Mobile response teams may use a standardized screening and assessment tool to help promote shared understanding across providers. Standardized tools are also intended to reduce the impacts of bias. Common tools include:

- [Crisis Assessment Tool](#) (CAT), a “decision support and communication tool to allow for the rapid and consistent communication of the needs of children experiencing a crisis” (The John Praed Foundation, n.d.-a)
- [Child and Adolescent Needs and Strengths](#) (CANS), a tool developed for child-serving systems “to facilitate the linkage between the assessment process and the design of individualized service plans” (The John Praed Foundation, n.d.-b; Manley et al., 2018)
- The [Child and Adolescent Service Intensity Instrument](#) (CASII), “a standardized assessment tool that provides a determination of the appropriate level of service intensity needed by a child or adolescent and his or her family” (American Academy of Child and Adolescent Psychiatry, n.d.; Manley et al., 2018)

- [Columbia-Suicide Severity Rating Scale \(C-SSRS\)](#) is an evidence-supported questionnaire used by numerous organizations to assess immediate risk of suicide, including by Lifeline centers.

Onsite Needs: De-escalation Strategies

De-escalation strategies are intended to increase safety while decreasing emotional distress. Sometimes this requires helping family members to recognize their own behavior in that moment, because it can be difficult for a young person to be calm if their family member is at a heightened emotional state (Shepler, 2021). Examples of de-escalation strategies include (Bostic & Hoover, 2020; Shepler, 2021; National Alliance on Mental Illness Minnesota, 2018):

- Establishing safety in the immediate environment
- Projecting a calm, empathetic demeanor, with a soothing voice and slow movements
- Engaging in active and reflective listening, not trying to reason or argue with the person in crisis, and avoiding judgment
- Respecting the young person's physical space
- Decreasing stimulation; alternatively, providing a distraction, such as listening to music
- Taking a movement break
- Deep breathing and grounding exercises
- Journaling or creating art
- Sensory soothing (e.g., blankets, soothing smells, feel of warm water)

Spotlight: Mobile Response and Stabilization Services (MRSS)

Mobile Response and Stabilization Services (MRSS) is a youth- and family-specific crisis intervention model that recognizes the developmental needs of children, the role of families or caregivers, and the importance of avoiding out-of-home placements or the removal of youth from their school and community. MRSS models have been implemented in numerous states and localities (Manley et al., 2021).

MRSS is rooted in System of Care principles, which promote youth-guided, family-driven, community-based, and culturally and linguistically responsive services (Davis, 2018). Key components of MRSS include (Manley et al., 2021):

- The youth, family, or caregiver defines the crisis, and the MRSS responds 24/7 to meet their sense of urgency
- Single point of access and “no wrong door” approach
- The mobile response team is dispatched to provide services in person when available
- Responders support children and families in their natural environments
- Staffing does not rely on crisis responders from predominately adult-oriented systems
- MRSS partners with all child-serving systems
- Initial mobile response services may continue over a period of 72 hours, as needed
- Stabilization supports may continue for up to 8 weeks, as needed; e.g., in-home support, respite care, short-term care coordination

- Outcome data is tracked, reported, and used for quality improvement purposes

To learn more about MRSS, access [Mobile Response & Stabilization](#) (University of Maryland); [Making The Case for a Comprehensive Children’s Crisis Continuum of Care](#) (Manley et al., 2018); or Ohio’s [Mobile Response Stabilization Service Tool Kit and Resource Guide V1.0](#).

Onsite Needs: Safety Planning

Creating a **crisis or suicide safety plan** is a key component of ensuring the young person’s short-term safety and long-term stability. This should be a collaborative and strengths-based process that identifies and integrates their natural supports. SAMHSA describes safety planning in their [Treatment for Suicidal Ideation, Self-Harm, and Suicide Attempts Among Youth](#) Evidence-based Resource Guide (SAMHSA, 2020b):

“Safety planning is a collaborative process in which an individual and provider work together to develop a personalized list of coping strategies the individual can use during times of increased suicide risk. Safety planning is brief, effective, and can be done by any health professional with training. **Safety planning should be universally available for youth at risk of suicide.**” (p. 10)

“A safety plan is a prioritized list of coping strategies and sources of support that youth can use before or during a suicidal crisis and is often completed before starting treatment and/or during the first session. Safety plans are based on clear communication and a collaborative relationship between the client and provider.... Clinicians should collaborate with youth and their parents (if it is safe and appropriate to involve the family) at the beginning of a treatment program to develop a safety plan that is brief, in the youth’s own words, and easy to read.” (p. 34)

Examples include:

- The [Stanley-Brown Safety Plan](#) is a widely used, one-page, evidence-informed tool. There is also a [series of brief training videos](#) available that models each step in the plan, as well as an iOS-based [Stanley-Brown Safety Plan](#) mobile application (“app”).
- The Parent/Professional Advocacy League (PPAL) and the Massachusetts Behavioral Health Partnership (MBHP) developed a set of three [Crisis Planning](#) tools to help families and youth prepare their essential information and preferences in advance of crisis.

Onsite and Post-Crisis Needs: Care Coordination and Follow-up

Mobile response teams may coordinate a transition to community-based mental health services, crisis receiving and stabilization services (described in the next section), or a hospital setting.

- Know the crisis and medical facilities in the region, and also the broader array of child and adolescent supports and services. These include local behavioral health providers, school-based supports, and other county and community resources (e.g., housing support) (Bostic & Hoover, 2020). Include resources and supports that are designed for specific communities, such as drop-in centers for LGBTQI+ youth.

- If needed for the young person’s safety and stability, provide a warm hand-off to a crisis receiving and stabilization facility. In some instances, such as if the young person is in medical distress or in imminent risk of harming themselves or others, it may be necessary to transition to a hospital. In both cases, provide transportation as needed.
- Provide a warm hand-off for appointments with appropriate local providers for ongoing care after a crisis episode, if needed, with consent from the family.

Mobile response teams typically provide some level of follow-up. For example, MRSS teams provide up to eight weeks of follow-up stabilization services. In other models, follow-up may be limited to check-ins over the first one to two weeks to ensure that youth and families transitioned to further services, if needed.

Youth Crisis Response Case Example: Brandon, Age 15

Vignette adapted and shortened from a case study presented in Singer, J. B. (2015). Crisis Intervention Handbook: Assessment, Treatment, and Research, Fourth Edition.

Staff at a youth homeless shelter call the mobile crisis response team for 15-year-old Brandon, who has run away from home and has made comments that he does not care if he dies. Brandon has experienced recurring homelessness in the past with his mother, as well as abuse from men involved with his mother.

The mobile crisis worker works to build rapport by showing willingness to listen without interruption, empathizing, and providing opportunities for Brandon to take ownership of his decisions. Brandon shares that he would like to hurt his mother’s boyfriend, but he is several states away and Brandon shows no interest in returning to where the boyfriend is, so the crisis worker considers Brandon to be at low risk of violence toward others. The crisis worker talks with Brandon to name and validate his feelings and to try to identify the precipitating event that provoked him to run away.

Together, the crisis worker and Brandon brainstorm possible solutions to his problem of not having a place to live (e.g., stay with an aunt), and develop a specific action plan with measurable and realistic steps (e.g., call the aunt). The final stage is follow-up. Brandon’s aunt purchases a train ticket for him for the following day, and the crisis worker meets Brandon at the train station. They discuss Brandon’s plans for the next 24 hours, and Brandon agrees that he will call or text the crisis worker when he arrives at his aunt’s house or if there are problems when he arrives.

A Safe Place to Be – Crisis Receiving and Stabilization Services

Crisis receiving and stabilization services are essential for youth who require additional crisis support beyond what mobile response teams can provide, but who do not need hospitalization. There are several kinds of crisis receiving and stabilization services, including both in-home supports and facilities. SAMHSA strongly prioritizes home-based de-escalation and stabilization supports for youth.

Every community’s emergency department should be equipped to address youth behavioral health in a developmentally appropriate, culturally responsive, and trauma-informed manner.

Crisis Receiving and Stabilization Service Types

Youth crisis services are centered on de-escalation and stabilization within the home and community. **This is an important priority for all crisis services, but it is especially important for youth.** Every effort should be made to maintain the young person in their current living environment, ideally with the active participation of family members and other natural supports.

However, there are times when the safest and best management of a situation involves inpatient care or out-of-home crisis stabilization. When young people receive out-of-home services, the priority should be to transition them back to home and to appropriate services in the community (as needed) as soon as it is safe to do so.

In this section, stabilization facilities are described first, because they are intended to support the young person's immediate safety in the initial hours or days after a crisis begins. This is followed by a description of in-home stabilization supports, which may be provided over a longer period of several weeks.

Crisis Receiving and Stabilization Facilities

There are several types of crisis facilities that can help youth when they have more intensive care and safety needs than can be met through home- and community-based services. Examples include crisis stabilization centers, 23-hour beds/observation units, respite care, walk-in services, and the Living Room Model (Saxon et al., 2018). Depending on the young person's needs, facilities can offer a safe environment and short-term care that effectively diverts youth from hospitalization, or they can function as a step-down service after hospitalization.

The shared goal of these services is to help youth return home and transition them to outpatient supports (if needed) as quickly as possible (SAMHSA, 2014a). Some residential settings, such as respite care facilities, are also intended to reduce strain on families and prevent longer-term out-of-home placements (Bruns & Burchard, 2000). Crisis stabilization facilities often have a small number of beds (e.g., 6-16), and they may operate in a residential, home-like setting (Saxon et al., 2018). They also typically have a maximum period of stay, ranging from less than a day (23-hour units) up to two or three weeks.

Sample services include assessment, rapid stabilization, observation, medication management, peer support, brief individual and family counseling, care coordination and service linkages, and discharge planning, among others. Facilities are often staffed by peer support providers and other crisis response paraprofessionals or professionals. Psychiatrists, psychiatric nurse practitioners, or physicians may provide supervision and medical consultation (Saxon et al., 2018).

In-Home Stabilization

In-home stabilization services may serve as a bridge that helps youth transition from immediate crisis services (e.g., mobile response, crisis facilities) to ongoing care in the community. In-home stabilization components are provided as soon as practicable and may continue for several weeks. For example, in the MRSS model, in-home stabilization services are provided for up to eight weeks, while other models range from 6-16 weeks (Hepburn, 2021a).

Services may be provided by a therapist or clinician in partnership with a paraprofessional, who can help youth and families implement the plan that they identify with their therapist (Hepburn, 2021a; Williams, 2018). Sample in-home services include assessment, parent education programs, peer support, coping and conflict management skill-building, behavior management training, and warm hand-offs to other resources and services. Stabilization can also involve evidence-based therapies for the young person and their family, such as Functional Family Therapy, Trauma-Focused Cognitive Behavioral Therapy, Multidimensional Family Therapy, or Multisystemic Therapy (The Institute for Innovation and Implementation, 2021).

Stabilization providers collaborate with the youth and family as active partners to develop goals that are integrated into a crisis plan of care. This involves identifying unmet needs, communication challenges, underlying concerns, individual strengths, and coping strategies. Importantly, services are provided to both the youth and their family. Too often, families have felt sidelined by service providers who focus exclusively on the young person, without sufficiently considering important family dynamics or the supports that family members need (Hepburn, 2022a).

Expectations and Best Practices

The following recommendations adapt and expand on the guidance provided in the *National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit*, integrating best practices from the research literature, learnings from communities, and guidance from SAMHSA’s Children’s Crisis Continuum expert panel. Some of these guidelines are more relevant for facility-based crisis stabilization than in-home supports.

Essential Operations

- Accept all youth referrals, at least 90% of the time, with a “no rejection” policy for first responders. Offer walk-in and first responder drop-off options that accept youth (SAMHSA, 2020a).
- Offer developmentally appropriate services to address mental health and substance use crisis issues impacting youth.
- Do not require medical clearance prior to admission; instead, provide assessment and support for medical stability while in the program (SAMHSA, 2020a).
- Include beds within the real-time regional bed registry system, identifying how many beds are available for youth (see [Note about Bed Registries](#)).
- Collect data on crisis resolution, user satisfaction, and other outcomes, and review these data to develop quality improvement plans.

Staffing and Training

- Be staffed at all times with a multidisciplinary team with expertise in meeting the needs of youth, which may include: youth and family peer support providers; psychiatrists, psychiatric nurse practitioners, or physicians; social workers, counselors, and crisis specialists (SAMHSA, 2020a).
- Have staff who can assess physical health needs and deliver care for most minor physical health challenges. Have an identified pathway to transfer the young person to more medically staffed services, if needed (Bostic & Hoover, 2020).

- Ensure that staff have appropriate youth and family expertise and experience. For important training topics, see the sections on [Crisis Call Center Staffing and Training](#), [Mobile Response Staffing and Training](#), and [Special Populations](#).
- Provide training to all staff on effective crisis management strategies that minimize the use of seclusion and restraint. Staff should also be trained in the safe, respectful, and appropriate use of seclusion and restraint. Such actions should only be used by trained personnel as a last resort and for brief periods of time (see [Safety/Security for Staff and People in Crisis](#)).

Facility Setting

- If the facility serves both youth and adults, have separate receiving and support areas. If the facility serves both younger children and adolescents, it is also ideal to have separate areas for them (Bostic & Hoover, 2020).
- Provide spaces that are trauma-informed in their design and that promote dignity as well as safety (e.g., open and airy design with inviting colors; no barriers, such as Plexiglass, that separate or isolate people in crisis) (SAMHSA, 2014c).
- Provide spaces that are calming and welcoming and that offer developmentally suitable supports for youth and families (e.g., privacy for adolescents, space for young children to play safely) (Bostic & Hoover, 2020).
- Provide confidential spaces for families to gather, with the young person and without, where they may receive clinical services and support (Bostic & Hoover, 2020).

Providing Services

- Screen for risk of self-harm, suicide, and risk for violence using tools that are designed or appropriate for youth. For examples, see [Onsite Needs: Assessment Tools](#).
- If short-term individual and family therapies are provided, integrate community-defined evidence programs and cultural adaptations of evidence-based interventions, in addition to traditional evidence-based interventions (National Latino Behavioral Health Association, 2021).
- Provide warm hand-offs to home- and community-based, youth-serving care.
- Incorporate some form of intensive support beds, either within the facility's own child and youth services area or with a partner that also offers children- and youth-specific crisis services.

Youth Crisis Response Case Example: Nikki, Age 8

Vignette adapted from a case study presented in Singer, J. B. (2015). "Child and Adolescent Psychiatric Emergencies: Mobile Crisis Response." Crisis Intervention Handbook: Assessment, Treatment, and Research, Fourth Edition.

Repeated Access to Mobile Response Services and Follow-up

A school counselor contacts the mobile crisis unit to request a suicide assessment for Nikki, an 8-year-old girl, who has drawn pictures of herself with knives cutting her body. Nikki has previously had fights with other children and frequent outbursts, including self-injurious behavior (e.g., biting her arms).

The crisis worker talks with Nikki and her mother separately in the school offices and identifies that Nikki has had suicidal ideation for years. Nikki's mother, Jamie, shares that she has been diagnosed with bipolar disorder, but does not currently take medication or receive therapy; she also conveys that she is angry with Nikki for the child's behavior.

The mobile team's on-call psychiatrist reviews Nikki's assessment and does not believe that she is at imminent risk of harm. The crisis worker develops a safety plan with Nikki and Jamie, but Nikki is not transferred to crisis receiving or stabilization services. Although the safety plan identifies that Jamie will resume taking her medication, as well as meet weekly with the mobile response team worker, neither of these things happen.

There is a second crisis incident in which Nikki cuts herself with a knife and the mobile response team is called out. The crisis worker (in consultation with the crisis team's on-call psychiatrist) recommends that Nikki stay with her grandmother temporarily, and Jamie agrees. During this time, the crisis worker meets weekly with Jamie to discuss the problems their family is experiencing and brainstorm solutions in a way that empowers Jamie. Together, they formulate an action plan to transition away from crisis services (e.g., to a community-based Family Preservation Program that will help Jamie avoid out-of-home placement for Nikki). Approximately two months after initial contact, Nikki and Jamie are fully transitioned to the community-based program, and Nikki is no longer a risk to herself or others.

Core Values and Principles

SAMHSA's *National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit* established six core principles for crisis response systems. This section explores how each of the core principles can be specifically applied to children's and youth crisis care.

1. Addressing Recovery Needs
2. Trauma-Informed Care
3. Significant Role for Peers
4. Zero Suicide/Suicide Safer Care
5. Safety/Security for Staff and People in Crisis
6. Crisis Response Partnerships with Law Enforcement, Dispatch, and Emergency Medical Services

In addition to these foundational principles for the broader crisis continuum, SAMHSA strongly emphasizes these values for the youth crisis continuum:

- Keeping youth within their homes and communities, when safe and appropriate to do so, is of paramount importance. Out-of-home placement should be avoided unless necessary for the safety and wellbeing of the young person and their family.
- Services must be developmentally appropriate and must treat youth *as* youth, not as small adults.
- People with lived experience, including family and youth peer supporters, must be integrated into service planning, implementation, and evaluation.
- Services must promote behavioral health equity. They should be culturally and linguistically responsive and designed to meet the needs of diverse youth and families (including racially, ethnically, linguistically, and sexual orientation and gender diversity).

Addressing Recovery Needs

A **recovery-oriented** approach to crisis focuses on promoting recovery, resiliency, respect, and empowerment for people with lived experience. It is a person-centered approach that involves *working with* the person in crisis to reduce risk to themselves and others, instead of treating the person in crisis as if they are a risk.

This recovery-oriented approach is aligned with the core tenets of the System of Care (SOC) approach. The SOC approach affirms that youth experiencing behavioral health challenges and their families should be full partners in determining their care. The SOC approach also promotes well-coordinated services across systems (e.g., between schools and mental health providers) and emphasizes the need for community-based services (Stroul et al., 2021). SOC is described in detail in the [Connecting to the System of Care](#) section.

Addressing recovery needs involves actively engaging youth and families in a shared decision-making process that explores their preferences and priorities, providing them with information about the supports that are available, and helping them make care-related decisions that align with their priorities. Staff should also support youth in identifying their strengths and natural supports, both in immediate crisis planning and in follow-up care and stabilization. Natural supports may include cultural and faith communities, sports teams, mentoring, volunteer roles, or other extracurricular activities and relationships that support positive youth development and social engagement.

Summary of Implementation Strategies

- Meaningfully integrate the SOC values of *family-driven, youth-guided, and culturally and linguistically responsive* at every level of service. Respect the preferences of youth and families as much as possible while ensuring safety.
- Create engaging environments that do not use barriers to separate or isolate people in crisis (SAMHSA, 2020a).
- Engage youth and families in shared decision-making.
- Support youth in identifying their strengths and natural supports that will aid their recovery.
- Ensure that multilingual staff or translation supports are available so that youth and families accurately understand the choices available to them.

Trauma-Informed Care

Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically and emotionally harmful or threatening and that has lasting adverse effects on the individual's physical, social, emotional, or spiritual well-being (SAMHSA, 2014b). It is important to know that people can experience trauma because of things that happen directly to them, and also because of things that happen to their loved ones; experiences in their community; natural or person-made disasters; or historical and cultural events, such as forced family separations or genocide.

Unfortunately, there are many aspects of traditional crisis response systems that can be traumatizing or retraumatizing for youth and families, such as out-of-home placements, physical restraint, and experiences or fears of being harmed by law enforcement (Mental Health America, 2017; National Council for Behavioral Health, 2021).

A trauma-informed approach promotes a sense of safety, trustworthiness, and empowerment. SAMHSA defined the “four Rs” of a trauma-informed approach (SAMHSA, 2014b). In a crisis response system:

- All staff in the crisis response system **realize** that trauma is a major contributor to behavioral health crises. They also know that past trauma and community trauma impact how crisis services are perceived.
- Staff in the crisis response system can **recognize** the signs of trauma, including those that are specific to children and adolescents.
- The program, organization, and system **respond** to these realities by applying a trauma-informed approach into all aspects of services.
- Organizations seek to **resist re-traumatization** of both the people they serve and their own staff or volunteers. For example, they do not place a child who has been traumatized by familial neglect into a seclusion room.

While a trauma-informed approach is important for all crisis response services, it is especially crucial for working with youth, who are still developing the coping and resiliency skills they need to respond to events that may be traumatic.

Summary of Implementation Strategies

- Seek to employ staff that reflect the racial, ethnic, sexual orientation and gender identity, cultural, and linguistic diversity of the community to be served.
- Ensure that crisis call center, mobile response team, and crisis stabilization services staff receive training on trauma-informed care.
- Promote use of strengths-based approaches that support young people's resiliency and acknowledge that healing from trauma is possible.
- Provide training to key systems partners (e.g., schools, law enforcement) on trauma and trauma-informed crisis management approaches that limit the use of seclusion and restraint, including de-escalation training (Manley et al., 2018).
- Integrate trauma screening (e.g., Trauma Screening, Brief Intervention, and Referral to Treatment, also known as T-SBIRT). Ensure that staff are trained to implement trauma screenings in a sensitive and developmentally appropriate way (Wisconsin Department of Health Services, 2018).
- Provide training to staff and volunteers about secondary traumatic stress, including the unique stress of working with children who have been traumatized.

Significant Role for Peers

People with lived experience can provide support to others facing similar behavioral health challenges. People with lived experience who serve as peer support specialists receive specialized training in how to use their own experiences to help other people. They inspire hope, a sense of connection, and empowerment, which can help others move from crisis to recovery (Masselli et al., n.d.).

Crisis response programs have integrated peers within their crisis call centers, mobile response teams, crisis facilities, and follow-up stabilization supports. Peer support is discussed in more detail in the [Core Services](#) sections. Note that many states and organizations have age requirements for youth and young adult peer supporters, often starting between the ages of 14 and 18 and going up to ages 26 to 30.

Peer support providers serve as both on-the-ground staff and as leadership. In a crisis, they can help to quickly build trust and a sense of safety. After immediate crisis, peer specialists can also support families in navigating services (SAMHSA, 2017; Walker et al., 2018).

Summary of Implementation Strategies

- Hire youth and family peer support providers. As much as possible, peer supporters should reflect the communities served (e.g., BIPOC families, LGBTQI+ youth).
- Provide ongoing support, training, and developmentally appropriate supervision for peer support providers.
- Integrate peers within each of the core services (crisis call centers, each mobile response team, and at crisis receiving and stabilization facilities).
- Refer families and youth to peer support services in their local area.

Zero Suicide/Suicide Safer Care

Suicide prevention is a core responsibility of crisis intervention services. The [Zero Suicide](#) framework from the Educational Development Center (EDC) focuses on preventing suicide deaths in healthcare and

behavioral healthcare settings by promoting safer suicide care at the systems and organizational levels. The following are the seven core elements of the Zero Suicide model (Education Development Center, n.d.-a):

- **Lead** system-wide culture change committed to reducing suicides.
- **Train** a competent, confident, and caring workforce.
- **Identify** individuals with suicide risk via comprehensive screening and assessment.
- **Engage** all individuals at-risk of suicide using a suicide care management plan.
- **Treat** suicidal thoughts and behaviors directly using evidence-based treatments.
- **Transition** individuals through care with warm hand-offs and supportive contacts.
- **Improve** policies and procedures through continuous quality improvement.

For children and youth, EDC specifies:

“Suicide prevention and treatment for youth must be developmentally appropriate, attend to critical social determinants of health, assess the presence of adverse childhood events (ACEs) and trauma, incorporate parental or guardian support, and address consent considerations.” (Education Development Center, n.d.-b)

SAMHSA’s *National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit* notes that the Zero Suicide model is also strongly aligned with Lifeline protocols for risk assessment, engagement, and follow-up (SAMHSA, 2020a).

Summary of Implementation Strategies

- **Lead:** commit to a goal of Zero Suicide for children and youth as a crisis response system.
- **Train** staff in how to talk to youth and families about suicide, how to use non-stigmatizing language and trauma-informed approaches to youth considering or attempting suicide, and when and how to assess for imminent risk.
- **Identify** youth at risk of suicide using evidence-based assessment tools. Examples include the Ask Suicide-Screening Questions (ASQ) tool, designed for screening youth ages 10-24 in medical settings (see [ASQ Toolkit](#)), or the Columbia-Suicide Severity Rating Scale (C-SSRS), which offers [resources for implementing the C-SSRS in various settings](#).
- **Engage** youth using developmentally appropriate suicide safety planning tools. For more information, see the [Onsite Needs: Safety Planning](#) section of this guide.
- **Treat:** youth at risk of suicide should receive appropriate care that directly addresses their suicide risk and behavioral health crisis, rather than being subjected to police detainment, seclusion, long periods of ED boarding, or similar practices.
- After the immediate crisis response and stabilization, **transition** young people to appropriate, community-based services that address long-term suicide risk and behavioral health needs.
- **Improve** policies and practices: collect and regularly review data related to youth and families who call in for suicide-related concerns, youth who screen positively for suicide risk, and their outcomes (e.g., follow-up supports).

Safety/Security for Staff and People in Crisis

Ensuring the safety of youth in crisis and the people around them is foundational to crisis care. One safety issue of special concern to the youth crisis system is seclusion and restraint. Seclusion refers to confining a

young person to a space or isolated area (e.g., a locked room). Restraint includes both physical means of restricting movement and chemical means (e.g., sedatives).

Physical restraint and seclusion are used on youth in residential treatment settings at higher rates than on adults in care. These practices can be traumatizing for both youth and families, and they are associated with frequent injuries to youth, deaths, and injuries to staff (Bystrynski, 2021). **SAMHSA is committed to reducing and ultimately eliminating the use of seclusion and restraint, with the goal of creating care environments that are free of coercion and violence** (SAMHSA, 2022).

Summary of Implementation Strategies

- Commit to a “no force first” policy to minimize the use of seclusion and restraint (SAMHSA, 2020a).
- Provide comprehensive staff training on the experiences of youth placed in restraint or seclusion; trauma-informed approaches; and effective, person-centered alternatives to restraint and seclusion (Craig & Sanders, 2018). Including youth and families to talk about their experiences with seclusion and restraint is an effective part of training (Bryson et al., 2017).
- If seclusion or restraint occur, both the staff and the young person should be debriefed, together or separately depending on the needs of the young person. (Craig & Sanders, 2018; Reddy et al., 2017).
- Employ prevention strategies to limit situations that may result in seclusion or restraint, such as individual assessments for risk of violence and active safety planning (Reddy et al., 2017).
- Create spaces that feel safe, comfortable/comforting, and nonconfining (Reddy et al., 2017). Provide youth-specific areas so that they are not exposed to adults in crisis.
- When promoting 988 or other crisis response services, use images and messaging that communicate a sense of physical and emotional safety.

Crisis Response Partnerships with Law Enforcement, Dispatch, and Emergency Medical Services (EMS)

It is essential for the behavioral health crisis response system—including 988 crisis contact centers—to build partnerships with traditional first responders. In many regions, police and 911 are still the primary response system for crises of any kind, for both youth and adults.

Many localities have implemented “co-responder” models in which a law enforcement officer or EMS provider and a mobile crisis team are trained and resourced to respond to behavioral health crises together (sometimes via telehealth). Some researchers and organizations have argued that this practice harms communities of color and contributes to fear of contacting mobile response teams (Bunts, 2022). SAMHSA’s *National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit* encourages crisis teams to safely reduce unnecessary criminal justice system involvement unless the encounter merits law enforcement intervention. There are many co-responder models, and these programs should be adapted for local contexts, cultural responsiveness within the community, and developmental appropriateness (when involving youth) (Balfour et al., 2020; Krider et al., 2020).

Summary of Implementation Strategies

- Provide Crisis Intervention Team for Youth (CIT-Y) trainings or similar curricula to law enforcement, including school resource officers and other law enforcement officers embedded in youth-serving agencies.
- Establish clear policies and protocols for 911 dispatch to divert calls to the crisis response system, when appropriate to do so.
- If they are not co-responders, train crisis response staff on when to contact law enforcement or emergency medical services.
- If possible, co-locate crisis call center responders and/or mobile crisis teams with 911 services (Hepburn, 2021b).
- Have local crisis responders, including youth and family peer supporters as feasible, participate in trainings with law enforcement on topics related to the partnership.
- Incorporate regular meetings between crisis response and first responders to identify and address challenges. Discussion topics should include strategies to better respond to youth, families, and youth-serving agencies like schools (SAMHSA, 2020a). Use these as opportunities to create shared language as well.
- When appropriate, adopt a “no refusal” policy for first responders and law enforcement bringing youth to crisis receiving facilities and expedite the process in lieu of justice settings (Hepburn, 2021b).
- Provide training specific to responding to youth with disabilities (see [Youth with Intellectual and Developmental Disabilities \(IDDs\)](#)).
- Share aggregate data regarding youth- and family-related calls to crisis call centers and 911 to identify opportunities for outreach, awareness building, and diversion.

Connecting to the System of Care

For youth and families, a strong crisis response system needs to be more than just resources and services. It will require policies and practices that are aligned with the System of Care (SOC) values of being family driven, youth guided, trauma informed, and culturally and linguistically responsive (Stroul et al., 2021).

The crisis response system is one component of a constellation of services for youth with behavioral health needs. SOC is an essential framework for understanding how families receive services, and why it is important to coordinate among youth-serving systems (e.g., children's mental health, child welfare, juvenile justice, primary care, and schools). First developed to serve children and youth with serious emotional disorders and their families, the SOC approach has since expanded into a concept that may be applied to any population that receives services and supports from multiple agencies or providers (Stroul et al., 2015).

The System of Care framework comprises three components (Stroul et al., 2021):

1. **Philosophy:** services should be family-driven, youth-guided, developmentally appropriate, strengths-based, trauma-informed, community-based, and culturally and linguistically responsive. The SOC philosophy also emphasizes care coordination, interagency collaboration, least-restrictive settings, and interventions that are evidence-based or based on community-defined evidence (National Latino Behavioral Health Association, 2021).
2. **Infrastructure:** an infrastructure is needed to develop policies and procedures that reflect a SOC approach. Examples of infrastructure components include, but are not limited to, provider partnership and collaboration agreements; data-sharing agreements; financing approaches; and partnerships across systems, across agencies, and with youth- and family-run organizations.
3. **Services and Supports:** the SOC approach recognizes that individual therapy, medication, and inpatient or residential treatment are part of a broader array of important supports. The SOC model emphasizes community-based services and supports that help keep children and youth in their homes.

SAMHSA encourages youth and family crisis response systems to adopt and integrate the SOC philosophy. A crucial component of this is to emphasize supports that keep youth in their own homes, schools, and communities. Other strategies for aligning with the SOC philosophy are discussed throughout this document.

Note that youth and family crisis services are not intended to take the place of a local SOC. The SOC approach is a best-practice model for supporting the *long-term* recovery, functioning, and wellness of children, youth, and young adults with behavioral health needs. Crisis services, on the other hand, focus on the young person's safety and stability *during* crisis and in the *immediate* aftermath (potentially up to several weeks).

[Spotlight: Wraparound Model](#)

Families and youth that repeatedly use crisis services may have needs that are not easily met through a warm hand-off to a community-based service. Youth with complex service needs, including youth who are involved in multiple systems, may be eligible for intensive care coordination. Many states and

localities have adopted the Wraparound model of intensive care coordination. Wraparound is a structured model in which a care coordinator convenes a team that includes the young person, family, clinicians, and natural supports. The team works collaboratively to develop, implement, and monitor an individualized plan of care based on identified strengths, needs, and goals (SAMHSA, 2019a).

In some areas, Wraparound care coordination and mobile crisis services are provided by the same entity. For example, [Wraparound Milwaukee](#) contracts with community agencies to provide care coordination and also offers the Children’s Mobile Crisis Team (formerly known as the [Mobile Urgent Treatment Team, or MUTT](#)). Crisis response service providers can also refer eligible youth and families to local Wraparound programs.

Key System of Care Partners

Crisis response agencies should develop informal relationships and formal partnerships with local youth-serving agencies. Crisis services staff should be trained and equipped to provide referrals and warm hand-offs to home- and community-based services and supports across the SOC.

The following are examples of how crisis response systems may effectively coordinate and collaborate with service providers in the broader SOC.

Schools

Schools are critical partners for youth and family crisis services (Centers for Medicare & Medicaid Services, 2021). Most children interact with the education system far more than any other youth-serving system. Schools are also the second-most common place where children receive behavioral health services (closely following specialty mental health settings) (Center for Behavioral Health Statistics and Quality, 2020). Unfortunately, as described elsewhere in this document ([Traditional Youth Crisis System](#)), students experiencing crisis—particularly BIPOC and LGBTQI+ students—have frequently experienced policing and harsh discipline rather than appropriate care. Crisis response services can divert students from these outcomes, with the goal of returning students to their classroom and their normal school activities as quickly as possible (Manley, 2021).

When a student is experiencing behavioral health crisis in school, appropriate personnel (e.g., school-based mental health providers) should engage the student in de-escalation activities before contacting crisis services and while waiting for the mobile response team to arrive (if needed) (Zenn & Moore, 2021). There are many de-escalation trainings that schools can access; one example is the Crisis Prevention Institute’s [Nonviolent Crisis Intervention](#). Certified or licensed school personnel or a telehealth provider may also complete a risk assessment with the young person. Mobile responders and school-based mental health professionals should receive training on using the same risk assessment protocols (e.g., Columbia-Suicide Severity Rating Scale) (Moore et al., 2021).

The University of South Florida created an infographic that shows sample steps for schools in their [Best Practices Response Protocol for Schools to Use Mobile Response Teams](#) document.

Crisis system leaders and school partners can offer cross-training on topics that are important in their own communities (e.g., support for students experiencing homelessness, how parents can access support for children with Autism) (Gasperini, 2021). Crisis responders should be knowledgeable about school-specific concerns and procedures, such as parental consent and confidentiality requirements. Regular meetings can

include mobile response team members and key partners such as school personnel, law enforcement, and other key partners at both the community and state levels. These meetings can be a place for discussing current challenges and identifying useful trainings (Moore et al., 2021).

Establishing formal partnerships, such as Memoranda of Agreement (MOA), can facilitate effective mobile response for students in crisis in schools. Connecticut's Emergency Mobile Psychiatric Services (EMPS) program has posted its current [MOA with Schools](#) to its website. These may serve as a model, although MOA should be customized to align with state and local laws, regulations, and resources. Sample MOA components include:

- Purposes of the MOA: maintaining student safety, improving care coordination, reducing juvenile justice system involvement and hospitalizations, etc.
- Roles and responsibilities of the mobile response team, such as hours of availability, timeframe for arriving after dispatch, services provided, and communication expectations.
- Roles and responsibilities of the school or district, such as using a mobile response telehealth platform, contacting caregiver(s), and providing onsite space for consultation.
- Mutual responsibilities that are shared by the school and mobile crisis response teams.
- Signatures from the crisis response service provider and a responsible authority in the school or district.

Community Organizations

The crisis response system should complement, not replace, community-based services for youth and families. There are several key connecting points for crisis response agencies and community partners.

Before a crisis, it is helpful to engage in dedicated outreach to community partners to raise awareness around the new 988 number, help them understand what crisis services are available, and explain when and how to access crisis support. Crisis response approaches may also involve training community and faith partners.

During a crisis, responders can help youth and their families identify their natural supports in the community. This may include afterschool and recreational programs, faith-based communities, and cultural organizations, for example. Involving family and youth peer supporters is another way that crisis response systems can build connections between individuals in crisis and their broader community.

In the follow-up to a crisis, responders may provide a warm hand-off to community-based services for longer-term stabilization and care (Bostic & Hoover, 2020). Examples of these kinds of services include in-home treatment interventions, family resource centers (FRCs), peer support programs, positive youth development programs, and caregiver education programs (Kurtz et al., 2020). Crisis responders may also refer families to community service agencies that help families meet their basic needs (e.g., food, housing, utilities, clothing). It is important for crisis responders to have strong understanding of the regional and local community-based services available to families.

Child Welfare and Foster Care

Youth involved in the child welfare and foster care systems are at higher risk for experiencing complex trauma and trauma-related behaviors. As many as 90 percent of youth in foster care have been exposed to

trauma, including personal experiences of abuse and neglect (Dorsey et al., 2012). Up to 80 percent of youth in foster care have a significant mental health need (Szilagyi et al., 2015).

Crisis response systems are encouraged to formalize partnerships with child welfare and foster care agencies to establish clear roles and agreements (Centers for Medicare & Medicaid Services, 2021). For example, in Milwaukee, the child welfare agency and the mobile crisis team established a unique MOA and funding for a dedicated crisis team for children in the foster care system. This partnership resulted in 90 percent of youth being stabilized in their current foster home (Karmadt & Morano, 2018). For all youth, the priority is to avoid removing youth from their current home unless necessary for their safety, including foster homes. Crisis response programs have been effective in reducing foster care placement disruptions (Casey Family Programs, 2018a; Shannahan & Fields, 2016).

Strong partnerships between child welfare agencies and crisis response providers can help ensure that foster parents know when to contact crisis services and what to expect (Children’s Behavioral Health Initiative, 2015). Some programs have established crisis response services to support youth who have just experienced out-of-home placement. New Jersey’s MRSS, for example, automatically dispatches a team member to meet with the young person at their foster placement or relative’s home within the first 72 hours of their removal from home. This program has helped to improve placement stability for young people (Casey Family Programs, 2018b).

Juvenile Justice

Nearly 70 percent of children in the juvenile justice system have a diagnosable behavioral health disorder (Bostic & Hoover, 2020). An important role of crisis response is to divert young people from the justice system when appropriate. See the section on [Crisis Response Partnerships with Law Enforcement, Dispatch, and Emergency Medical Services \(EMS\)](#) for more information.

Crisis response service providers are strongly encouraged to form partnerships with juvenile justice agencies (Optum, n.d.). At the state level, some agencies that are responsible for implementing 988 have formed cross-system partnerships with groups like Crisis Intervention Team steering committees, criminal justice planning councils, or police-mental health collaborations (Council of State Governments Justice Center, 2022). At the regional or local level, partnership activities may include regular meetings, cross-education and training, data-sharing agreements, sharing of screening tools, and development of protocols for when and how to contact crisis services (Wasserman et al., 2021).

Juvenile justice systems involve multiple agencies whose roles vary across states and localities (e.g., probation, juvenile court, centralized intake centers). Crisis response systems should be available to provide supports at multiple points in the process, including reentry (Manauha et al., 2020).

Pediatricians and Other Primary Care Providers

Many families talk to their child’s primary care provider about behavioral health concerns. Primary care providers can be especially helpful partners in raising awareness of 988 among families (Bostic & Hoover, 2020). At the state level, state Medicaid agencies are charged with ensuring that mobile crisis teams maintain relationships with relevant community partners, included primary care providers such as pediatricians (Centers for Medicare & Medicaid Services, 2021). At the local level, crisis follow-up and

stabilization supports can include referring families to primary care providers or coordinating with the young person's provider (NASMHPD, 2022).

Primary care providers should have strong understanding of when and how to contact crisis services, including what to expect. Additionally, crisis response services (such as mobile teams) may provide training to primary care partners on de-escalation strategies that they can use with youth and/or share with families.

Spotlight: Child Psychiatry Access Programs (CPAPs)

Most states, and several U.S. territories and Tribal communities, have established or been funded to establish Child Psychiatry Access Programs (CPAPs). The Massachusetts CPAP launched in the mid-2000s to provide primary care providers and pediatricians consultation with specialty care child psychiatrists, and the program has since been replicated widely (National Network of Child Psychiatric Access Programs, n.d.). These services are not a replacement for an integrated crisis response system. However, they can be an important tool for outreach and partnership with rural primary care providers, and they can support primary care providers in identifying when additional crisis supports are needed (Bostic & Hoover, 2020).

Homeless Shelters and Transitional Housing Programs

A significant minority of children, youth, and young adults experience homelessness. In 2019, 27% of people experiencing homelessness were under age 24, and 19% were under age 18 (U.S. Department of Housing and Urban Development, 2019). Some young people are at greater risk for experiencing homelessness, including youth and young adults who are Black, Hispanic or Latino, LGBTQI+, or parents (Morton et al., 2017). There are many different ways a young person can experience homelessness: they may be unaccompanied or with their family; they may be unhoused for a short period of time, a long period, or across multiple periods; and they may be unsheltered, in a shelter, or in another unhoused living situation. It is crucial to ensure that the young person has safe and stable housing, but safety is unique to the young person's needs (living with immediate family, living with extended family, living in low-barrier independent housing, etc.) (Morton et al., 2017).

There should be strong partnerships between crisis response services and the homeless shelters and transitional housing programs that support youth and families. These partnerships help crisis responders connect unhoused youth and families to community services, including emergency housing when needed (Committee on Psychiatry, 2021). Collaboration also helps homeless providers understand when to contact the crisis response service and promote it in the community (Usher et al., 2019). Cross-training between these services enables everyone to better identify and respond to the needs of youth and families experiencing homelessness.

Special Populations

Children and youth have unique needs, strengths, and service experiences that vary across different groups and populations. This section identifies some of the youth populations that have special service needs. This section is not comprehensive. As youth crisis response systems continue to grow nationwide, SAMHSA's intention is to provide more guidance about serving these populations and other youth populations with high needs, unmet needs, or unique needs.

Early Childhood

Crisis response often focuses on adolescents and adults, although infants and very young children also have mental and developmental health needs. In addition, the behavioral health of a young child's caregiver may need to be addressed. Behavioral health crisis teams must be able to respond to children across the lifespan and to the caregivers of young children.

Infants, toddlers, and young children have different signs of distress than school-age children. Examples may include excessive fussiness, intense separation anxiety, violent tantrums, and feeding or sleeping issues. Specialized experience may be necessary to assess whether young children's behaviors are typical or concerning. For example, a crisis response team may have a psychiatrist with early childhood expertise available for telephone or video consultation, or counselors who are trained in infant and early childhood mental health consultation.

All staff should receive training around family relationships and family engagement, which includes understanding how caregiver mental health can impact children (SAMHSA, n.d.). Parents of infants have unique mental health risks. An estimated 15-20% of women and 10% of men experience perinatal mood and anxiety disorders during pregnancy or in the year after childbirth (Lomonaco-Haycraft et al., 2018). For example, research has also found important disparities in postpartum care: Black women, Latina women, and women with Medicaid insurance are less likely than other women to receive postpartum mental health screening or treatment (Sidebottom et al., 2021).

As with older children and youth, SAMHSA strongly emphasizes the importance of avoiding out-of-placements for young children, except as necessary to ensure safety. When assessing safety, it is important to know that young children are especially vulnerable to abuse and neglect. Nationwide, more than one-quarter of children who are maltreated are in the age range of birth through two years old. Seventy percent of children who die from maltreatment are under age three (U.S. Department of Health & Human Services, 2021).

Mobile response and stabilization providers must collaborate with families. This must include respectful, ongoing engagement to understand familial perspectives, lived experiences, strengths, and needs (SAMHSA, n.d.). Family stabilization services and supports may take the form of parent coaching, postpartum behavioral health treatment, stress management, wellness education, or referrals to family-run centers (FRCs), for example.

To help ensure that early childhood crisis services are reimbursable through Medicaid, the *DC:0-5 Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* should be adopted (Clark, 2018). *DC:0-5* provides developmentally specific diagnostic criteria that are unique to infants, toddlers, and young children. States may formally integrate the *DC:0-5* into their

Medicaid policy and require that providers use it for early childhood diagnosis. In regions where the *DC:0-5* is not formally recognized, providers may use national or state-specific crosswalks that align *DC:0-5* diagnoses with billable diagnoses from the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* or *International Statistical Classification of Diseases and Related Health Problems (ICD)* (Szekeley et al., 2018).

Summary of Implementation Strategies

- Equip staff to refer families to the local and regional resources that are available to caregivers of young children, including young children who may have developmental delays. This should include basic needs resources (e.g., Women, Infants, and Children [WIC] food benefits).
- Train staff in how to identify signs of abuse or neglect in infants and young children, how to respond, and when and how to report.
- Ensure that crisis call center and mobile response team staff have access to clinicians with expertise in the mental health and development of infants, toddlers, and young children, including the use of evidence-based screening and assessment.
- Include early childhood care providers and educators in outreach activities related to 988 and accessing crisis services (e.g., pediatricians, Head Start and Early Head Start programs, home visiting programs).
- Integrate *DC:0-5* diagnoses into state policy and local practice.

Transition-Age Youth (TAY) and Young Adults

TAY generally refers to young people at the developmental stage of transitioning from childhood to adulthood. It is used differently in different contexts, but generally refers to adolescence through approximately age 25.

There are several unique needs and challenges involved in providing crisis response services to TAY. The majority of mental health challenges emerge in adolescence through young adulthood (Jones, 2013; Solmi et al., 2022). Serious mental illnesses are more prevalent during the transition age than at any other period (SAMHSA, 2018; Zajac et al., 2013).

Young adulthood also involves the transition from child-serving systems (foster care, juvenile justice, special education, pediatric care, etc.) to adult-serving systems. Children's services typically have age requirements that vary from system to system, and often do not consider individual needs. Rather than a streamlined system of care, many youth and young adults experience a series of transition tunnels and cliffs (Babajide et al., 2020). This can make it challenging for youth with behavioral health needs to access new services or continue existing services.

TAY are also in a developmental period that is often characterized by a need for independence alongside a continued need for familial supports. For youth under 18 years old, parental consent to receive crisis services may or may not be required, depending on state law (SchoolHouse Connection, 2021; Tawa & Westbay, 2020). Even if parental consent is not required, some youth may elect to involve their family or other natural supports in developing their plan of care. SAMHSA strongly encourages respect for the autonomy of the youth, and the inclusion of family and other supports, wherever possible, in addressing crisis and crisis resolution. Providers and policies should encourage the young person to engage their families in crisis care planning while recognizing that family relationships, treatment history, and previous

experiences of removal/out-of-home placement may affect the young person's willingness to do so (Children's Behavioral Health Initiative, 2015).

Crisis response services must have policies in place addressing when and how a young person's health information can be shared with family members and/or other service providers if they are 18 or older. In general, the Health Insurance Portability and Accountability Act (HIPAA), 42 Code of Federal Regulations Part 2, and the Federal Education Rights and Privacy Act (FERPA) permit providers to disclose protected health information when the health or safety of an individual or the public is at imminent risk *and* the information is being shared with someone who can reduce or eliminate that risk. State laws may also impose additional privacy protections on sharing this type of information (Draper et al., 2015).

Summary of Implementation Strategies

- TAY with lived experience should have authentic, non-tokenized roles in planning, implementing, and evaluating crisis response systems that serve youth.
- Offer TAY-specific crisis stabilization facilities.
- Engage youth and young adults as peer support providers. Provide developmentally appropriate training, supervision, and supports.
- Provide training and clear policies around obtaining caregiver consent for services and sharing health information with families.
- Be prepared to refer TAY to county and community services that address a range of transition needs, including supports for life skills development, secondary education transitions, and employment.
- Form strong partnerships with foster care agencies: youth transitioning out of foster care are at higher risk for experiencing homelessness and other crises.

Youth with Intellectual and Developmental Disabilities (IDDs)

People with IDD have often been left out of the planning of mental health and crisis response services, even though they are at higher risk for co-occurring mental health conditions. Children and youth with IDD have a risk of developing mental health challenges that is three to four times higher than that of other young people (Munir, 2016; Pinals et al., 2017).

Police officers may have limited or no training on de-escalation with people who have IDD, which can lead to excessive force or deaths (Criminal Justice, 2021; Hepburn, 2022b). Similar challenges impact young people in schools. In 2014, students with disabilities represented 12% of students overall, but were 58% of the students placed in seclusion or confinement and 75% of the students who were physically restrained (U.S. Department of Education Office for Civil Rights, 2014).

Many of the same crisis response practices apply for youth with IDD as for other youth: focus on safety, assess for risk, engage in de-escalation, and create a plan for next steps and continued safety. As with all youth, out-of-home placement should be avoided unless necessary for safety. It is important to note that youth with IDD “are more likely to be neglected, sexually abused, emotionally abused, and physically abused than children without such disabilities” (Pinals et al., 2017).

Youth with IDD are typically more dependent on family members than youth without disabilities, and family members are often their primary natural supports (Primm, 2021). Because of this, families are much

more likely to be very involved in crisis management and stabilization supports or therapies (Trauma and Intellectual/Developmental Disability Collaborative Group, 2020). Lack of access to disability-competent, culturally responsive care is a significant challenge for many families (Hepburn, 2022b). For example, youth with IDD often face difficulty when transitioning to adult-serving systems, with some continuing to see pediatric clinicians well into adulthood (Bloom, 2012).

There are several interventions and statewide models that incorporate training specific to crisis response and IDD. Examples include:

- The National Center for START (Systemic, Therapeutic, Assessment, Resources, and Treatment) Services, which offers a [series of trainings](#) on this evidence-informed model to provide community-based crisis intervention for individuals with IDD and mental health needs. Twelve states have certified START programs in place.
- [Pathways to Justice](#) is a community-based model to support justice partnership and reform for people with disabilities. Pathways participants receive support to create a local, multi-disciplinary Disability Response Team as well as training for local responders.
- The [Mental Health and Developmental Disabilities National Training Center](#) offers no-cost trainings, webinars, and resources, including some that are specific to crisis response.
- [REACH \(Regional Educational Assessment Crisis Services Habilitation\)](#) is from the Virginia Department of Behavioral Health and Developmental Services, which provides crisis response services statewide to individuals with IDD. Among other supports, they offer a Youth REACH Crisis Therapeutic Home for young people with IDD in need of brief residential crisis support.

Summary of Implementation Strategies

- As with all youth, provide trauma-informed, person-centered, and strengths-based crisis support.
- At the state and local level partner with agencies that have IDD specialization, such as Councils on Developmental Disability, Centers for Independent Living, and University Centers for Excellence in Developmental Disabilities (Hepburn, 2022b).
- Provide staff trainings on important topics such as: effective communication (e.g., being aware of sensory challenges, not talking about people with IDD as if they are not there, using short sentences); incorporating family into de-escalation strategies; safety planning (Primm, 2021).
- Train staff to assess for abuse and neglect of youth with disabilities, including IDD.
- Have access to providers with IDD-related expertise, whether in person or through telehealth.
- Be prepared to refer families to specialized IDD supports in the community, such as early intervention services, functional behavioral assessment, applied behavior analysis, function-based treatment, and caregiver education (Kurtz et al., 2020).
- Engage families in a way that is appropriate to the young person's needs and be prepared to adapt strategies to include family members.

LGBTQI+ Youth

A trauma-informed, culturally, and linguistically responsive system must include attention to the needs of LGBTQI+ people in crisis. A recent survey of youth who identify as LGBTQI+ found that “42 percent...including more than half of transgender and nonbinary youth, seriously considered attempting suicide in the past year. Nearly half of respondents could not access the mental health care they desired” (The Trevor Project, 2021).

Youth who identify as LGBTQI+ are also at increased risk of homelessness compared to their peers (see [Homeless Shelters and Transitional Housing Programs](#)). One study found that nearly one-third of youth contacting a national LGBTQ crisis hotline had experienced homelessness in their lifetime, and that their risk was higher if they had disclosed their identity to their parents or experienced parental rejection (Rhoades et al., 2018). Training related to LGBTQI+ youth should include discussion of family dynamics, the family acceptance model (SAMHSA, 2014d), and special considerations for preventing LGBTQI+ youth homelessness.

The National Suicide Hotline Designation Act of 2020 (S.2661), otherwise known as the 988 bill, recognizes that LGBTQI+ youth are at higher risk of suicide than their heterosexual and cisgender peers. The 988 bill encourages a strategy for call responders to receive LGBTQI+ cultural competency training and for callers to have access to LGBTQI+ specific services.

One component of person-centered care is understanding that LGBTQI+ youth may be especially reluctant or afraid to engage with law enforcement, medical or mental health professionals, shelter staff, and others because of past experiences of discrimination (National Resource Center on LGBTQ+ Aging, n.d.). Gender-diverse youth can also experience discrimination and barriers to crisis care, especially facility-based care. Some crisis stabilization facilities, short-term residential programs, youth shelters, and similar settings are specific to “boys” or “girls,” without making accommodations for transgender boys and girls or nonbinary youth (Shelton, 2015).

Summary of Implementation Strategies

- Provide training for all staff on affirming, responsive, and appropriate supports for LGBTQI+ youth, including the use of pronouns and preferred names (True Colors United, 2019; Bostic & Hoover, 2020).
- At the local or regional level, maintain lists of LGBTQI+ affirming organizations and providers in the community for successfully transitioning LGBTQI+ youth to community services they will actually use (National Resource Center on LGBTQ+ Aging, n.d.).
- Engage in outreach efforts to LGBTQI+ youth and LGBTQI+ youth-serving organizations. Clearly present crisis services as inclusive and LGBTQI+ affirming.
- Recruit diverse peer support providers, including LGBTQI+ youth and young adults (Wisconsin Department of Health Services, 2018).
- Adopt non-discrimination policies, processes, and procedures that prioritize the physical and emotional safety of LGBTQI+ program participants. LGBTQI+ people with lived experience should be involved in the development of policies (Shelton, 2015).
- Build strong partnerships with homeless prevention organizations and shelters to help protect LGBTQI+ youth from housing instability (Rhoades et al., 2018).

Rural and Frontier Communities

Youth in rural counties have poorer access to behavioral health services than those in urban or suburban counties. Much of the U.S. includes a rural county or health professional shortage area. While roughly two-thirds of all U.S. counties had at least one mental health facility serving youth, fewer than one-third of all highly rural counties had such a facility (Graves et al., 2020).

Rural and frontier communities face significant barriers in developing and implementing behavioral health crisis services. Large geographic areas, combined with a limited workforce, can make it difficult to deliver services in a timely manner. Some rural residents may not be able to afford the cost of health insurance or the cost of out-of-pocket care if they lack health insurance, which is more common in rural areas than urban areas (National Conference of State Legislatures, 2020).

Three recent, SAMHSA-funded publications provide detailed discussion of the challenges and innovative solutions to implementing crisis response systems in rural, frontier, and Tribal regions:

- [*Mental Health System Development in Rural and Remote Areas during COVID-19*](#) (NASMHPD, 2021)
- [*Strategies for the Delivery of Behavioral Health Crisis Services in Rural and Frontier Areas of the U.S.*](#) (NASMHPD, 2020)
- [*Tailoring Crisis Response and Pre-Arrest Diversion Models for Rural Communities*](#) (SAMHSA, 2019)
- [*Cultural Elements of Native Mental Health with a Focus on Rural Issues*](#) (Northwest Mental Health Technology Transfer Center [MHTTC], 2022)

To avoid duplication with existing documents, this section focuses on rural crisis response considerations that are specific to youth and families.

Many rural regions are working to supplement their workforce with non-traditional mental health providers. For example, Behavioral Health Aide program in Alaska and the Community Health Aide Program from Indian Health Services train individuals (who do not have formal backgrounds in mental health) to respond to behavioral health crisis and provide therapeutic services in rural and Tribal communities. Community- and faith-based organizations and events can be another way to embed mental health awareness into non-traditional, comfortable settings (e.g., conference for young ranchers) (Neylon, 2020).

Family and youth peers can also help grow the regional crisis response workforce and serve an essential role in breaking down stigma around mental health services in rural areas. SAMHSA's *National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit* recommends that the police should not be dispatched to crisis situations unless it is appropriate to the specific crisis, or other behavioral health responders are not available. However, in rural and frontier areas, there may not be other options. Partnering a peer co-responder with law enforcement can help to de-escalate crisis situations where law enforcement are the only available responders.

Long transportation times between where a mobile response team is located, where the crisis is happening, and where there is an available crisis facility (for those who need it) pose a major challenge in rural areas. One strategy is to implement a statewide electronic bed registry system that includes information about beds available to children and youth (see [Note about Bed Registries](#)) (Neylon, 2020).

In rural regions, where there is less access to specialized services in general, it is often important to find ways to build on established programs rather than developing new programs. This can include providing new tools and resources to existing staff and providing specialized, youth-specific training to responders who address a broad range of crises. For example, in urban areas, only a portion of law enforcement officers may receive Crisis Intervention Training (CIT). Conversely, in a rural area with a smaller staff and larger

geographic area, it may be necessary to train all officers in CIT (including the CIT for Youth add-on or similar curriculum) (SAMHSA, 2019b).

Telehealth is a crucial strategy for addressing the challenges of rural and frontier workforce shortages and delivering services over a wide geographic area. Sharing technologies can help to streamline connections between first responders and crisis response teams. For example, Nevada’s rural schools, hospitals, and juvenile detention centers are equipped with the same telehealth program that the Rural Mobile Crisis Response Team uses, which facilitates faster response times (Rural Children’s Mental Health Consortium, 2018). Law enforcement or emergency medical services (EMS) providers can use mobile tablets to connect with mobile response teams or telehealth providers who deliver assessment and counseling directly to people in crisis (Neylon, 2020; SAMHSA, 2019b).

Summary of Implementation Strategies

- Expand the workforce of family and youth peers, community health workers, and others who are not mental health clinicians, but who receive specialized crisis response training and who have ties to their communities.
- Raise awareness and improve literacy around youth mental health communities through programs such as Youth Mental Health First Aid (Y/MHFA) and partnerships with community and faith organizations.
- For primary care providers (PCPs), participate in virtual learning models such as Project ECHO (Extension for Community Healthcare Outcomes) in which specialists train PCPs to recognize and respond to youth behavioral health challenges.
- Establish partnerships with rural health clinics and rural hospitals so that the mobile response team is called when youth come in for mental health crisis. Partner with rural clinic case managers for coordinating follow-up and stabilization supports (Rural Children’s Mental Health Consortium, 2018).
- Share technology resources and telehealth applications with key systems partners.
- Integrate information about youth-specific services into electronic bed registries.

Conclusion

With the transition to 988 in July 2022, communities nationwide are seeking to build, expand, and improve their behavioral health crisis response systems. It is essential that we recognize the crisis needs of youth and families and amplify their voices in designing these systems.

This document shares learnings from decades of work by thousands of dedicated individuals striving to create state and local systems that meet the unique developmental needs of young people and honor the important role of families. These innovative programs are successfully linking youth and families to much needed supports in the community, from the Emergency Mobile Psychiatric Services (EMPS) in Connecticut to the Children’s Crisis Outreach Response System (CCORS) in King County, Washington, and in a growing number of states and localities in between. Together, we can work to create a trauma-informed, equity-driven, developmentally appropriate crisis system that is truly responsive to the needs of youth and families in every community.

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Appendix I: Summary of Implementation Strategies

The following table provides easy reference to strategies discussed throughout the National Guidelines for Child and Youth Behavioral Health Crisis Care.

CORE CRISIS PRINCIPLES

Adapted from SAMHSA's National Guidelines for Behavioral Health Crisis Care – Best Practice Toolkit

TOPIC	SUMMARY OF IMPLEMENTATION STRATEGIES
<u>ADDRESSING RECOVERY NEEDS</u>	<ul style="list-style-type: none">• Meaningfully integrate the SOC values of <i>family-driven, youth-guided, and culturally and linguistically responsive</i> at every level of service. Respect the preferences of youth and families as much as possible while ensuring safety.• Create engaging environments that do not use barriers to separate or isolate people in crisis (SAMHSA, 2020a).• Engage youth and families in shared decision-making.• Support youth in identifying their strengths and natural supports that will aid their recovery. <p>Ensure that multilingual staff or translation supports are available so that youth and families accurately understand the choices available to them.</p>
<u>TRAUMA-INFORMED CARE</u>	<ul style="list-style-type: none">• Seek to employ staff that reflect the racial, ethnic, sexual orientation and gender identity, cultural, and linguistic diversity of the community to be served.• Ensure that crisis call center, mobile response team, and crisis stabilization services staff receive training on trauma-informed care.• Promote use of strengths-based approaches that support young people's resiliency and acknowledge that healing from trauma is possible.• Provide training to key systems partners (e.g., schools, law enforcement), including de-escalation training, on trauma and trauma-informed crisis management approaches that limit the use of seclusion and restraint when appropriate (Manley et al., 2018).• Integrate trauma screening (e.g., Trauma Screening, Brief Intervention, and Referral to Treatment, also known as T-SBIRT). Ensure that staff are trained to implement trauma screenings in a sensitive and developmentally appropriate way (Wisconsin Department of Health Services, 2018).

TOPIC	SUMMARY OF IMPLEMENTATION STRATEGIES
	Provide training to staff and volunteers about secondary traumatic stress, including the unique stress of working with children who have been traumatized.
<u>SIGNIFICANT ROLE FOR PEERS</u>	<ul style="list-style-type: none"> • Hire youth and family peer support providers. As much as possible, peer supporters should reflect the communities served (e.g., BIPOC families, LGBTQI+ youth). • Provide ongoing support, training, and developmentally appropriate supervision for peer support providers. • Integrate peers within each of the core services (crisis call centers, each mobile response team, and at crisis receiving and stabilization facilities). <p>Refer families and youth to peer support services in their local area.</p>
<u>ZERO SUICIDE/SAFER SUICIDE CARE</u>	<ul style="list-style-type: none"> • Lead: commit to a goal of Zero Suicide for children and youth as a crisis response system. • Train staff in how to talk to youth and families about suicide, how to use non-stigmatizing language and trauma-informed approaches to youth considering or attempting suicide, and when and how to assess for imminent risk. • Identify youth at risk of suicide using evidence-based assessment tools. Examples include the Ask Suicide-Screening Questions (ASQ) tool, designed for screening youth ages 10-24 in medical settings (see <u>ASQ Toolkit</u>), or the Columbia-Suicide Severity Rating Scale (C-SSRS), which offers <u>resources for implementing the C-SSRS in various settings</u>. • Engage youth using developmentally appropriate suicide safety planning tools. For more information, see the <u>Onsite Needs: Safety Planning</u> section of this guide. • Treat: youth at risk of suicide should receive appropriate care that directly addresses their suicide risk and behavioral health crisis, rather than being subjected to police detainment, seclusion, long periods of ED boarding, or similar practices. • After the immediate crisis response and stabilization, transition young people to appropriate, community-based services that address long-term suicide risk and behavioral health needs. <p>Improve policies and practices: collect and regularly review data related to youth and families who call in for suicide-related concerns, youth who screen positively for suicide risk, and their outcomes (e.g., follow-up supports).</p>

TOPIC	SUMMARY OF IMPLEMENTATION STRATEGIES
<u>SAFETY/SECURITY FOR STAFF AND PEOPLE IN CRISIS</u>	<ul style="list-style-type: none"> • Adopt a “no force first” policy to minimize the use of seclusion and restraint when appropriate(SAMHSA, 2020a). • Provide comprehensive staff training on the experiences of youth placed in restraint or seclusion; trauma-informed approaches; and effective, person-centered alternatives to restraint and seclusion when appropriate(Craig & Sanders, 2018). Including youth and families to talk about their experiences with seclusion and restraint is an effective part of training (Bryson et al., 2017). • If seclusion or restraint occur, both the staff and the young person should be debriefed, together or separately depending on the needs of the young person. (Craig & Sanders, 2018; Reddy et al., 2017). • Employ prevention strategies to limit situations that may result in seclusion or restraint, such as individual assessments for risk of violence and active safety planning (Reddy et al., 2017). • Create spaces that feel safe, comfortable/comforting, and nonconfining (Reddy et al., 2017). Provide youth-specific areas so that they are not exposed to adults in crisis. <p>When promoting 988 or other crisis response services, use images and messaging that communicate a sense of physical and emotional safety.</p>
<u>CRISIS RESPONSE PARTNERSHIPS WITH LAW ENFORCEMENT, DISPATCH, AND EMERGENCY MEDICAL SERVICES (EMS)</u>	<ul style="list-style-type: none"> • Provide Crisis Intervention Team for Youth (CIT-Y) trainings or similar curricula to law enforcement, such as de-escalation training, including school resource officers and other law enforcement officers embedded in youth-serving agencies. • Establish clear policies and protocols for 911 dispatch to divert calls to the crisis response system, when appropriate to do so. • If they are not co-responders, train crisis response staff on when to contact law enforcement or emergency medical services. • If possible, co-locate crisis call center responders and/or mobile crisis teams with 911 services (Hepburn, 2021b). • Have local crisis responders, including youth and family peer supporters as feasible, participate in trainings with law enforcement on topics related to the partnership. • Incorporate regular meetings between crisis response and first responders to identify and address challenges. Discussion topics should include strategies to better respond to youth, families, and youth-serving agencies like schools (SAMHSA, 2020a). Use these as opportunities to create shared language as well. • Adopt a “no refusal” policy for first responders and law enforcement bringing youth to crisis receiving facilities and expedite the process in lieu of justice settings when appropriate(Hepburn, 2021b). • Provide training specific to responding to youth with disabilities (see <u>Youth with Intellectual and Developmental Disabilities (IDDs)</u>).

TOPIC	SUMMARY OF IMPLEMENTATION STRATEGIES
	Share aggregate data regarding youth- and family-related calls to crisis call centers and 911 to identify opportunities for outreach, awareness building, and diversion.

SPECIAL POPULATIONS AND COMMUNITIES

TOPIC	SUMMARY OF IMPLEMENTATION STRATEGIES
<u>EARLY CHILDHOOD</u>	<ul style="list-style-type: none"> • Equip staff to refer families to the local and regional resources that are available to caregivers of young children, including young children who may have developmental delays. This should include basic needs resources (e.g., Women, Infants, and Children [WIC] food benefits). • Train staff in how to identify signs of abuse or neglect in infants and young children, how to respond, and when and how to report. • Crisis call center and mobile response team staff have access to clinicians with expertise in the mental health and development of infants, toddlers, and young children, including the use of evidence-based screening and assessment. • Early childhood care providers and educators are included in outreach related to 988 and accessing crisis services (e.g., pediatricians, Head Start and Early Head Start programs, home visiting programs). <p>Integrate <i>DC:0-5</i> diagnoses into state policy and local practice.</p>
<u>TRANSITION-AGE YOUTH (TAY) AND YOUNG ADULTS</u>	<ul style="list-style-type: none"> • TAY with lived experience should have authentic, non-tokenized roles in planning, implementing, and evaluating crisis response systems that serve youth. • Offer TAY-specific crisis stabilization facilities. • Engage youth and young adults as peer support providers. Provide developmentally appropriate training, supervision, and supports. • Provide training and clear policies around obtaining caregiver consent for services and sharing health information with families. • Be prepared to refer TAY to county and community services that address a range of transition needs, including supports for life skills development, secondary education transitions, and employment. <p>Form strong partnerships with foster care agencies: youth transitioning out of foster care are at higher risk for experiencing homelessness and other crises.</p>
<u>YOUTH WITH INTELLECTUAL AND</u>	<ul style="list-style-type: none"> • As with all youth, provide trauma-informed, person-centered, and strengths-based crisis support.

TOPIC	SUMMARY OF IMPLEMENTATION STRATEGIES
DEVELOPMENTAL DISABILITIES (IDDs)	<ul style="list-style-type: none"> • At the state and local level partner with agencies that have IDD specialization, such as Councils on Developmental Disability, Centers for Independent Living, and University Centers for Excellence in Developmental Disabilities (Hepburn, 2022b). • Provide staff trainings on important topics such as: effective communication (e.g., being aware of sensory challenges, not talking about people with IDD as if they are not there, using short sentences); incorporating family into de-escalation strategies; safety planning (Primm, 2021). • Train staff to assess for abuse and neglect of youth with disabilities, including IDD. • Have access to providers with IDD-related expertise, whether in person or through telehealth. • Be prepared to refer families to specialized IDD supports in the community, such as early intervention services, functional behavioral assessment, applied behavior analysis, function-based treatment, and caregiver education (Kurtz et al., 2020). <p>Engage families in a way that is appropriate to the young person’s needs and be prepared to adapt strategies to include family members.</p>
LGBTQI+ YOUTH	<ul style="list-style-type: none"> • Provide training for all staff on affirming, responsive, and appropriate supports for LGBTQI+ youth, including the use of pronouns and preferred names (True Colors United, 2019; Bostic & Hoover, 2020). • At the local or regional level, maintain lists of LGBTQI+ affirming organizations and providers in the community for successfully transitioning LGBTQI+ youth to community services they will actually use (National Resource Center on LGBTQ+ Aging, n.d.). • Engage in outreach efforts to LGBTQI+ youth and LGBTQI+ youth-serving organizations. Clearly present crisis services as inclusive and LGBTQI+ affirming. • Recruit diverse peer support providers, including LGBTQI+ youth and young adults (Wisconsin Department of Health Services, 2018). • Adopt non-discrimination policies, processes, and procedures that prioritize the physical and emotional safety of LGBTQI+ program participants. LGBTQI+ people with lived experience should be involved in the development of policies (Shelton, 2015). <p>Build strong partnerships with homeless prevention organizations and shelters to help protect LGBTQI+ youth from housing instability (Rhoades et al., 2018).</p>
RURAL AND FRONTIER COMMUNITIES	<ul style="list-style-type: none"> • Expand the workforce of family and youth peers, community health workers, and others who are not mental health clinicians, but who receive specialized crisis response training and who have ties to their communities.

TOPIC	SUMMARY OF IMPLEMENTATION STRATEGIES
	<ul style="list-style-type: none"> • Raise awareness and improve literacy around youth mental health communities through programs such as Youth Mental Health First Aid (Y/MHFA) and partnerships with community and faith organizations. • For primary care providers (PCPs), participate in virtual learning models such as Project ECHO (Extension for Community Healthcare Outcomes) in which specialists train PCPs to recognize and respond to youth behavioral health challenges. • Establish partnerships with rural health clinics and rural hospitals so that the mobile response team is called when youth come in for mental health crisis. Partner with rural clinic case managers for coordinating follow-up and stabilization supports (Rural Children's Mental Health Consortium, 2018). • Share technology resources and telehealth applications with key systems partners. <p>Integrate information about youth-specific services into electronic bed registries.</p>

